STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185127	A. BUILDING _____ B. WING _____	08/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE CENTRE FOR HEALTH AND REHABILITATION	642 NORTH THIRD STREET DANVILLE, KY 40422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 3-5, 2010. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, medical record reviews, and review of manufacturer's directions for use, it was determined the facility failed to ensure staff responsible for administering medications was aware of the indications for use, contraindications, and possible side effects of medication for one (1) of twenty-one (21) sampled residents (resident #15). The findings include: Review of the Physician's Desk Reference 2007 Third Edition revealed Sevelamer HCL (brand name Renvela) was indicated for the reduction of serum phosphorus in end stage renal disease. The medication was to be given with meals in order to bind to the phosphorus in foods to facilitate removal from the body. Contraindications for use of Renvela were hypophosphatemia or bowel obstruction. The medication should be used with caution for patients with dysphagia, swallowing disorders, severe gastrointestinal (GI) motility, or GI surgery. Precautions for the use of Renvela included monitoring serum calcium, bicarbonate, and	F 281	1. A clarification order was written for resident #15 indicating that Renvela was to be administered during meals. The medication administration record (MAR) for resident #15 was updated to reflect the clarification order. 2. A review of all resident's physician's orders will be conducted between 8/27//2010 and 9/15/2010, by the DNS and Unit managers, or their designees, to verify that medications specifically required to be given with meals are clarified on both the physician's orders and medication administration records (MARS). 3. In-service education will be provided for all licensed nurse staff, by the consultant pharmacist or Advanced Register Nurse Practitioner, or designee, between 8/30/2010 and 9/15/2010. The in-service will include information related to medications that should be administered with meals, as well as the requirement to consult a drug guide book (available at each station) for any medications for which the nurse	9/15/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Hyllens	Executive Director	8/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 chloride, and the manufacturer indicated Renvela could bind with other drugs. Review of the medical record of resident #15 revealed the patient had been admitted to the facility on September 6, 2005, with diagnoses that included Diabetes Mellitus, End Stage Renal Disease, and Hypertension. Review of the physician's orders dated May 25, 2010, for resident #15 revealed the resident was to receive three Renvela (Sevelamer) 800-milligram (mg) tablets three times a day. Review of the Medication Administration Record for resident #15 revealed the patient had been receiving the medication at 0800, 1400, and 2000. Review of the facility's meal times revealed breakfast was served at 0700, lunch at 1200, and dinner at 1700. Review of the laboratory results for resident #15 dated May 13, 2010, revealed the resident's serum phosphorus level (reference range 3.5 to 4.5 mg/dL) was 3.3 milligrams per deciliter (mg/dL), on June 17, 2010, the serum phosphorus level was 4.9 mg/dL, and on July 22, 2010, the resident's serum phosphorus level was 4.3 mg/dL. Resident #15 had not been receiving the Renvela in accordance with manufacturer's directions for use to ensure lowering of the resident's phosphorus level. Interview on August 4, 2010, at 4:05 p.m., with the Licensed Practical Nurse (LPN) responsible for medication administration for resident #15, revealed the LPN was unaware of the indications for use of Renvela, contraindications for the medication, or adverse effects of the medication. According to the LPN, the medication was given to dialysis patients and the LPN was unsure why the patient was receiving the medication. The LPN was unaware the medication was required to	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* may be unfamiliar with, in order to insure that it is administered properly. 4. All licensed nurse new hires will be required to successfully complete a medication administration exam, and med pass review, prior to administering medications independently. The review tool specifically prompts the reviewer (Staff Development Coordinator or designee) to verify that the nurse is consulting a drug guide for any medication that he/she is unfamiliar with in order to insure that the medication is administered correctly, and that potential side effects and adverse reactions are noted. All licensed staff will participate in a medication administration review at the time of their annual evaluation. The DNS, or designee, will review the results from the medication administration reviews during the monthly Performance improvement meeting. Any further corrective action will be initiated at that time.	

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F 281	Continued From page 2 be given with meals. Interview on August 4, 2010, at 4:05 p.m., with the Unit Manager responsible for supervising the unit where resident #15 resided was unaware of the indications for the use of Renvela, contraindications, or adverse effects of the medication. The Unit Manager was unaware the medication was required to be given with meals. Interview on August 4, 2010, at 4:05 p.m., with the Advanced Registered Nurse Practitioner (ARNP) who had written the order for resident #15 to receive Renvela revealed the ARNP was unaware of the indications for the use of Renvela. The ARNP was unaware the medication was required to be given with meals and did not order the medication with meals.	F 281	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** 5. All corrective actions will be completed by 9/15/2010.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain the kitchen in a sanitary manner. The findings include:	F 371	1. No residents were effected by the alleged deficient practice 2. All residents have the potential to be effected by the alleged deficient practice, therefore the interventions listed in #'s 3 and 4 below will be initiated. 3. A cleaning schedule (Nutritional Services Cleaning Schedule) was implemented on 8/26/2010 by the Nutritional Services Manager. The Nutritional Services Cleaning Schedule addresses the cleaning of all kitchen equipment and areas, (including those items/areas noted on the 2567).	9/15/2010

The Nutritional Services Cleaning Schedule

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F 371	Continued From page 3 An initial tour was conducted in the kitchen at 9:55 a.m. on August 3, 2010. During the tour the following pieces of equipment were observed to be in need of a thorough cleaning: 1. The tour revealed the blade of the electric can opener contained a black substance that appeared to be oil\grease. The substance could be removed by rubbing the blade. A dietary employee stated that the stainless steel part of the electric can opener was wiped off daily. However, the staff member was unable to tell the surveyor the date the can opener blade was last cleaned. 2. The confectioner's oven had food spills in the bottom of the oven. A dietary employee stated that the confectioner's oven was usually cleaned every other week, and wiped out every other day. However, the staff member said the oven had not been cleaned or wiped out the past two days (August 1-2, 2010) the employee had worked. 3. The grease trap underneath the range top was observed to be lined with aluminium foil and the foil contained an excessive amount of spilled food debris, including an egg shell. A dietary staff member said the grease trap had not been cleaned for a few days because the kitchen had been out of aluminum foil. 4. A pan located in the bottom of the reach-in refrigerator was observed to have an excessive buildup of food/debris. Interview with dietary staff at 10:15 a.m. on August 3, 2010, revealed staff was unable to give the surveyor the date the refrigerator was last cleaned. Dietary staff said the pan in the bottom of the refrigerator was used	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Nutritional Services Cleaning Schedule Lists all equipment and areas to be cleaned (including frequency) by day, week, and month. All dietary staff will attend in-service training, conducted by the Registered Dietician, or designee, between 8/30/2010 and 9/15/2010. The in-service training will include information related to the Nutritional Services Cleaning Schedule guidelines as well as the facility policy and procedure related to kitchen sanitation. 4. The Nutritional Services Manager/Registered Dietician or designee, will conduct "Nutritional Services Quick Rounds" daily in order to insure compliance with the Nutritional Services Cleaning Schedule. The Executive director, or designee, will conduct Nutritional Services Quick Rounds" at least once weekly, in order to validate compliance with the Nutritional Services Cleaning Schedule.	

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F 371	Continued From page 4 for eggs. A sanitation tour was conducted in the kitchen at 9:00 a.m. on August 5, 2010, accompanied by the Dietary Manager (DM). The DM said the equipment was cleaned approximately every three weeks when maintenance personnel power-washed the equipment outdoors.	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	The results of the Nutritional Services Quick Round audits will be discussed in the monthly Performance improvement meeting and necessary corrective actions will be taken as necessary. 5. All corrective actions will be completed by 9/15/2010. 1. No residents were effected by the alleged deficient practice 2. All residents have the potential to be effected by the alleged deficient practice, therefore the interventions listed in #'s 3 and 4 below will be initiated.	9/15/2010

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F 431	Continued From page 5 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide an appropriate storage area to maintain proper temperature controls for medications that were available for resident use. The findings include: Observation on August 5, 2010, at 9:40 a.m., of the Unit II Hall II medication room revealed the temperature of the room to be 82.4 degrees Fahrenheit. Observation revealed the medication room contained an emergency combination drug kit, containing 21 injectables, three inhalants, and four oral medications. The manufacturer's guidelines revealed these drugs were required to be stored at a temperature of 68-77 degrees Fahrenheit. An interview was conducted with the Unit Manager on August 5, 2010, at 9:45 a.m. The Unit Manager stated the facility did not monitor the temperature of this room and was not aware the room was too warm for the medications.	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3. The Maintenance Director repaired the vent in the medication room. Thermometers were installed by the Maintenance Director in each medication room. Licensed Nurses will receive in-service training conducted by the Staff Development Coordinator, or designee, between 8/30/2010 and 9/15/2010, related to the facility policy and procedure for storage of drugs and biologicals. The in-service will also outline the procedure for the implementation of a Medication Room Temperature Log. The Medication Room Temperature Log will be used to document the temperature of the medication rooms. Licensed nurses will be responsible to check the medication rooms at least once per shift and document the temperature on the Medication Room Temperature Log.	

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F 431	Continued From page 5 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide an appropriate storage area to maintain proper temperature controls for medications that were available for resident use. The findings include: Observation on August 5, 2010, at 9:40 a.m., of the Unit II Hall II medication room revealed the temperature of the room to be 82.4 degrees Fahrenheit. Observation revealed the medication room contained an emergency combination drug kit, containing 21 injectables, three inhalants, and four oral medications. The manufacturer's guidelines revealed these drugs were required to be stored at a temperature of 68-77 degrees Fahrenheit. An interview was conducted with the Unit Manager on August 5, 2010, at 9:45 a.m. The Unit Manager stated the facility did not monitor the temperature of this room and was not aware the room was too warm for the medications.	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The licensed nurses will be required to notify the maintenance personnel if the medication room temperature is outside of the acceptable range of 68-77 degrees Fahrenheit 4. The Staff Development Coordinator, or designee, will be responsible to review compliance with utilizing the Medication Room Temperature Logs weekly for one month, then monthly for two months. The results of compliance tracking, related to the Medication Room Temperature Logs, will be presented during the facility monthly Performance Improvement Meeting by the Staff Development Coordinator. Further corrective actions will be initiated as necessary at that time. 5. All corrective actions will be completed by 9/15/2010.	

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	185127	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/05/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 5, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all the residents. The facility has the capacity for 106 beds with a census of 101 on the day of survey. The findings include: During the Life Safety Code tour on August 3, 2010, at 8:40 a.m., with Maintenance staff, a battery located at the outside generator set was noted to contain corrosion around one of the battery terminals. The wiring to the battery	K 144	1. No residents were effected by the alleged deficient practice 2. All residents have the potential to be effected by the alleged deficient practice, therefore the interventions listed in #'s 3 and 4 below will be initiated. 3. The battery charger wiring was reconfigured per NFPA 110 specifications/guidelines. The reconfiguration allowed the wiring to be permanently connected directly to the starter and block, as opposed to the battery, per NFPA 110 specifications. The Maintenance Director and Maintenance Assistant received in-service training related to NFPA 110 guidelines, specific to back up generator guidelines, by the Regional Environmental Services Director the week of 8/30/2010.	9/15/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Robert Hellens | Executive Director | 8/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 144	Continued From page 1 charger was attached directly to the battery terminals. Battery chargers are not to be wired directly to the battery for safety and operational reasons. An interview with Maintenance staff on August 3, 2010, at 11:15 a.m., revealed Maintenance staff was not aware of the corrosion on the battery or that the battery charger was not connected correctly. A records check on August 3, 2010, at 12:15 p.m., with the Director of Maintenance revealed the generator battery was being checked weekly with no apparent problem. The Director of Maintenance stated different personnel check the generator and the Director of Maintenance was not aware of the problems associated with the generator set. Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. 6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.6-1.1* The routine maintenance and operational testing	K 144	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. In order to insure and monitor continued compliance with NFPA 110 guidelines, the battery generator will be checked weekly, per the Kindred Preventative Maintenance Program. The Maintenance Director will present the findings of his weekly generator checks to the facility Performance Improvement Committee monthly for three months. Any additional corrective actions will be initiated as necessary based on recommendations by the Performance Improvement Committee. 5. All corrective actions will be completed by 9/15/2010.	

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K 144	Continued From page 2 program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction. 6-4.7 The routine maintenance and operational testing program shall be overseen by a properly instructed individual.	K 144		